MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Jack A. Sloane, DC PO Box 1404 Decatur TX 75234	MDR Tracking No.: M4-03-7495-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 19 Fidelity & Guaranty Ins. c/o Flahive Ogden & Latson 505 W. 12th Austin TX 78701	Date of Injury: Employer's Name: Dillards, Inc. Insurance Carrier's No.: 89941356058228

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
6/5/02	**6/5/02**	**97139-AC(2 units involved)**	**$56.00**	**$56.00**
		(DOP)		

PART III: REQUESTOR'S POSITION SUMMARY

6/2/03: "There have been denials on multiple dates of service (DOS) that are not consistent with TWCC guidelines and/or the services provided…This denial did not satisfy the requirements of TWCC rule 133.304…To perform the services billed, Dr. Sloane maintained direct 1-on-1 physical, visual and verbal contact with the patient face to face, for 30-45 minutes. Electroauricular pain management is a very time intensive procedure that requires constant attendance and focus by the physician for the entire length of treatment (30-45 min)…services…were provided to relieve the pain so that the patient could participate in an active return-to-work rehab program…"

PART IV: RESPONDENT'S POSITION SUMMARY

7/7/03: "…Initial response. Carrier paid the disputed services in accordance with the appropriate fair and reasonable standard. The amount of reimbursement is in accordance with the database of charges maintained by AccuMed."

6/23/03: "…According to Rule 133.304 when a payment for treatment in which there has not been a MAR assigned by the Commission…carrier shall develop and consistently apply…" The carrier explained the methodology post submission to MDR by provider."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The requestor failed to submit documentation to support their fair and reasonable billing for this CPT code that does not have an established MAR according to rule 133.307(g)(3)(D and E). Therefore, reimbursement can not be recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
6/5/2002	97139-AC	$56.00	$0.00				
	involving 2 units						
					Total Left Column:		$56.00
					Total Amount Due:		$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to (additional) reimbursement.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Carol Lawrence	03/18/05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____